

MID MICHIGAN VASCULAR SURGERY

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Welcome! We are delighted to have you as our patient. Please help us obtain the yearly insurance signature and information that is required by law yearly. Thank you.

DATE COMPLETED: _____ **Please include front/back of ins card (EPIC also)**

PATIENT NAME: _____ SEX: M F SS# _____

D.O.B.: _____ AGE: _____ MARITAL STATUS: M S D W

ADDRESS: _____ CITY: _____ ST: _____

ZIP: _____

PHONE #: (HOME) _____ (WORK) _____ (CELL) _____

EMAIL: _____

IF MARRIED: SPOUSE NAME: _____ DOB: _____

PHONE#: _____

- IF YOU ARE UNDER YOUR SPOUSE'S INSURANCE WE WILL NEED ALL OF THEIR INFORMATION FILLED OUT ABOVE AND CARRIER SUBSCRIBER #

CARRIER SUBSCRIBER #: _____

If person resides in a skilled nursing facility, please indicate the facility here: _____

Address: _____ Phone #: _____ long term or short term

EMPLOYMENT STATUS: FULL TIME PART TIME DISABLED RETIRED

EMPLOYER: _____ RETIREMENT DATE: _____

REFERRING DOCTOR: _____ FAMILY DOCTOR:: _____

CARDIOLOGIST:: _____

INSURANCE: 1 _____ 2 _____ 3 _____

IS THIS A WORKMAN COMPENSATION CLAIM OR AUTO CLAIM? Y N

(IF YES) CLAIM#: _____ DATE OF INJURY: _____

Turn the page over to sign back, please and thank you!

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION AND MEDICARE INSURED PATIENTS:

**I hereby authorize Mid Michigan Vascular Surgery, P.C. to furnish my insurance company (s) or to a designated attorney all information which said insurance company (s) or attorney may request. Medical information may be released to said insurance company (s) in pursuit of payment for medical services on our behalf, where covered services are rendered and billable under the financial policy of this office. I understand that I am financially responsible to Mid Michigan Vascular Surgery, P.C. for charges not covered by this insurance assignment. I further agree, in the event of non-payment, to pay in full that which is due for services and to bear the cost of collection and/or court and reasonable legal fees, should this be required by Mid Michigan Vascular Surgery, P.C. to collect these fees for services.

**If I am a Medicare patient, I request that payment of authorized Medicare benefits be made on my behalf for any services furnished to me by this provider. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits for related services.

Please be aware that if you should refuse to sign this form, we will be unable to render medical services to you.

Signature of Patient: _____

Date of Signature: _____